

## PRIVATE HEALTH CARE IN SCOTLAND

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## Context

The problems encountered in the public/private health debate in England cannot be automatically transported to Scotland where the impact of government policy must be examined in the context of a different medical and cultural tradition. This article shall outline some of the significant features which differentiated Scottish and English medical care pre-1948 and go on to look at the present extent of private health provision and privatisation of NHS ancillary services in Scotland, highlighting areas where the Scottish response to the issue has differed from the English.

## Background

Scotland had no strong tradition of private health care prior to the introduction of the NHS in 1948. In England, however, financial problems in the 1920s had forced many hospitals, facing the prospect of closure, to introduce a scheme of hospital payments for those with a modest income who took out insurance and thus, particularly in London, had begun private wings and pay-beds. This, and the fact that Scottish teaching hospitals, unlike their English equivalents, had never charged fees, has important implications for the private sector, being indicative of the fact that the Scottish people have no tradition of paying for hospital care whereas the phenomenon is not new to England.

Another important historical factor which has led to a stronger tradition of support for the NHS in Scotland was the importance, during World War Two, of the Emergency Medical Service (EMS). This had proved that a state-run service could work thus allaying, in Scotland, many of the fears with which English doctors continued to view the prospect of a national health service. The success of the EMS also meant that at the end of the war Scotland had more hospital beds than England and hence received a larger percentage of the NHS budget. It may be argued that the relatively poorer health of the Scottish people justifies this discrimination but there can be little doubt that this pattern of funding was mainly the result of historical legacy and not needs-related. A stronger Scottish support for the NHS thus appears to be legitimated by the fact that with

more hospital beds and expenditure per head of population, more doctors and higher quality teaching hospitals, the Scottish NHS is regarded as being somewhat superior to that in England.

The social structure in Scotland is another important feature which must be taken into account in measuring the response to private provision. Scotland is politically socialist and, even if the majority of the population cannot be considered to be whole-heartedly ideologically opposed to private health care, certainly many could not afford the costs of private treatment. This is not to deny, however, that some more affluent parts of Scotland, such as Edinburgh, have their own history of private provision for the more wealthy.

Historically, therefore, it would appear that there has been no great demand for private health care because the voluntary sector and the NHS have proved adequate for meeting needs and a small private sector operated for those who could afford, and wished, to opt out of the state sector. The late 1970s/early 1980s, however, saw an increase in the number of Scottish subscribers to private health insurance schemes, an increase in private hospital provision and the prospect of the privatisation of NHS ancillary services – does this indicate increasing support for the private sector, disillusion with the NHS, or was the increase a one-off phenomenon which is already losing its relevance?

## Private Health Insurance

It is not possible to state with any great accuracy the number of subscribers to private health insurance in Scotland due to the fact that, of the three main provident associations, British United Provident Association (BUPA), Western Provident Association (WPA), and Private Patients Plan (PPP), only BUPA have headquarters in Scotland and this branch also covers Northumbria and Cumbria. Despite the lack of exact figures, however, BUPA estimated in 1984 that they had a total of 81,000 Scottish subscribers which would mean that approximately 180,000 – 200,000 people are provided with cover. In England the largest growth in subscribers occurred in 1980 but the largest growth in Scottish figures occurred in 1982 when BUPA's Edinburgh branch was the second most successful of the company's twenty-one branches. Between 1979 and 1984 BUPA subscribers in Scotland showed a *net* growth of 49.6%. This figure looks superficially very impressive but it must be regarded in the context of Scotland having started from a fairly low base rate. The growth rate has since slowed considerably and is estimated now to be steady at 4 – 5% a year.

The large increase in insurance subscribers may be thought to indicate an increased acceptance of the private sector by the Scottish people but it is important to look at the reasons why subscriptions have increased. People may choose private health care because it is offered at reduced rates through their place of work; because of a belief, particularly on the part of elderly people, that the NHS is a "charitable institution"; or because of dissatisfaction with the NHS. Half of BUPA's business comes from individual subscribers and the remaining 50% from company schemes whereas previously the figures would have read 70% individuals and 30% companies. It can thus be deduced that the "boom" years of health insurance have been largely attributable to the growth in company schemes. This begs the question whether people are then actually "choosing" private health or are they having the decision taken for them.

One of the main springboards for the growth in company schemes was the Incomes Policy of the late 1970s which left employers free to pay their workforce in a non-pecuniary manner and led to many companies who had previously offered private health insurance to their executive staff, extending the scheme, either by paying whole or part of the subscription, to the rest of their workforce. Incomes Policy also had other implications in that it led to strikes in the NHS which in turn led to longer waiting lists, a factor exploited by the private sector which was offering treatment at a time of the patient's own choosing.

In 1979 the Conservatives came to office with a market-oriented ideology which was held to favour the private insurance market. The private health sector was seen to exemplify the existence of freedom of choice for the consumer and the virtues of the free market economy, and it was believed that competition would stimulate performance in the NHS. At this time the private sector became more aggressive in its advertising, magnifying it greatly and increasingly making use of television. Despite government rhetoric of support for the sector, however, it appears to have done very little to actually encourage it or to provide concrete assistance, other than allowing premiums to be offset against corporation tax and treated as non-taxable benefit for those earning under £8,500 a year. They would actually appear to have adopted a stance of non-intervention, something which is viewed with disfavour by the industry which expected more substantial support and would like to see tax-relief extended to all premiums on account of the money the sector claims to save the NHS.

There has been some suggestion that the industry is nearing saturation point due to the fall in the Middle-Eastern market, the substantial rises in

premiums and the rising number of subscriptions, particularly in group schemes, which have been allowed to lapse, but the sector dispute that this is the case in Scotland. There is, however, no suggestion as was often claimed in the "boom" years, that the sector is setting itself up as a real threat to the NHS. The growth has, however, inevitably led to an increase in the level of private provision.

### Private Hospital Provision

Private hospital provision showed a remarkable growth in the late 1970s as a direct result of Labour's 1974 pay-beds policy which was designed to eliminate pay-beds from the NHS over an unspecified period of time and force the private sector to support itself. Scotland has only approximately 108 NHS pay-beds (the figure fluctuates) thus the demand from the increasing number of insurance subscribers has had to be met by an increase in private facilities. In 1948, what little private provision there was tended to be provided, in the main, by charitable religious hospitals and it is this pattern of care which has changed in recent years. The market is now dominated by commercial providers and the religious sector is waning. This trend was highlighted in Edinburgh when the public announcement of the closure of St Raphaels as a private surgical unit coincided with the announcement of the development of a new private hospital (Murrayfield), a joint venture between BUPA Hospitals and the Linen Bank. Both St Raphaels and BUPA deny that the imminent arrival of one forced the closure of the other but the matron of St Raphaels did admit that the religious order did not have the money or the inclination to meet the increasing demand for 5-star, hotel-like facilities which patients have come increasingly to expect. There has been some speculation that a similar situation may arise in Glasgow where the older, more traditional Bon Secours hospital faces competition from the very expensive and commercial Ross Hall private hospital and the Nuffield McAlpin Clinic.

There is very little private provision in the north of the country which has few NHS pay-beds and only one large, religious nursing home in Aberdeen. The central belt also has little provision although there has been an application by United Medical Enterprise (UME) to develop a new private hospital in Stirling. Provision is therefore, as may have been expected, heavily weighted towards the two largest cities although it may be considered surprising that Glasgow has such a surfeit of provision in comparison with Edinburgh.

## Summary of the main features of Scottish Private Provision

Location	Beds	Owned by
<b>Edinburgh</b>		
Private Clinic	18	Consortium
Murrayfield	60	BUPA Hospitals & Linen Bank – opened 1984 with 30 beds operational
St. Raphaels	41	Little Company of Mary – closed 1984 when it changed its function to a sheltered housing complex for elderly
<b>Glasgow</b>		
Bon Secours	63	Bon Secours Sisters
Nuffield McAlpin	50	Nuffield Hospitals
Ross Hall	101	Glasgow Independent Hospitals Ltd. – opened 1983 with 55 beds operational
<b>Aberdeen</b>		
St. John's Nursing Home	34	Order of St. John

Ross Hall hospital, hailed inaccurately as the first profit-making, commercial hospital in Scotland, opened in 1983 and is owned by Glasgow Independent Hospitals Limited and managed by American Medical International (AMI), who have the option to buy it in 1987. This large, converted stately home, with its museum-like interior in the old wing and clinically sterile new extension, epitomises the arrival of high-technology, commercial medicine in Scotland and stands in stark contrast with the older, traditional Bon Secours, its nearest geographical competitor. Glasgow District Council had twice turned down planning permission for the hospital but these decisions were overturned by the Secretary of State and Ross Hall has come to be somewhat of an enigma in the local neighbourhood where state provision of housing and health care are the norm.

The £7 million Murrayfield Hospital which opened in 1984, is inconspicuously situated on the outskirts of Edinburgh, although not as isolated as Ross Hall, and was built specifically as a “community hospital”. Whereas AMI usually wait for a community to approach them, BUPA Hospitals, who run Murrayfield, do desk surveys looking at population figures and beds in a given area and examine in detail with local consultants, work patterns and special equipment needs. By this means it was estimated

that Edinburgh would generate the demand for 60 beds. The effort to make it a “community” venture meant enlisting the involvement of the local financial community, local doctors and institutions. Murrayfield is popularly supposed to differ from Ross Hall in that the latter is still considered to be the “baddie” for being avowedly profit-oriented, but BUPA Hospitals are a profit-making organisation as are the seven other BUPA subsidiaries, with only BUPA itself not sharing this general orientation.

## Scottish Response to Private Provision

Ross Hall and Murrayfield have both had difficulties with the Blood Transfusion Service (BTS) which highlight the fact that the sector is still facing problems in becoming really established in Scotland, problems it never encountered in England. The BTS refused to handle blood supplies for Ross Hall until an undertaking had been signed that patients would not be charged for blood, that the blood would not be sold elsewhere, and that a technical and handling charge would be paid to the BTS. This situation had never arisen in England where AMI and similar profit-making hospitals had received blood and BTS services free of charge. Similarly, existing private facilities in Scotland had also received free BTS services so it is worth questioning why the issue arose in relation to Ross Hall and there appear to be three possible contributory factors. In the first instance Ross Hall was perceived, albeit incorrectly, to be the first profit-making hospital in Scotland. Secondly, the unions were becoming newly conscious and active on the issue of private health. In the third place, blood supplies in the West were fairly low and this had led to speculation that there might have to be a choice between supplying Ross Hall or supplying blood for cardiac surgery in Glasgow. It is unclear how much weight should be attributed to each factor but they culminated in a standard handling charge being introduced at a rate set by the DHSS.

The blood issue aroused strong anti-private feeling which was reflected in some unpleasant and strongly emotive letters sent to the BTS from long-standing donors. This is not the place to argue the relative merits of the issue – whether it is right that insured donors (a large amount of blood comes from workplace donations where the workforce are subscribers to private health insurance schemes) should be charged for blood, or that blood which donors believe is going to the NHS should then be supplied to private hospitals – but it serves to emphasise the differing reactions to the private sector in Scotland and England.

The BTS have also refused to provide Murrayfield Hospital with

technical assistance on the grounds that it would affect their service to NHS patients and by doing so are actually breaking their contract. It seems unlikely that the hospital will take legal action, however, having appeared to adopt a somewhat "easy-easy" attitude towards the unions. Whether this signifies fear of union action or is just a wise compromise by an institution which is still finding its feet and does not wish to alienate itself, is difficult to determine.

The blood issue may have died a temporary death, although there is still some debate over whether the charges which have been introduced actually reflect the true costs involved, but the issue did herald a new awareness of the issue of private health care in Scotland which is being kept alive by periodic media exposures of dubious practices. The unions, particularly the Association of Scientific, Technical and Managerial Staff (ASTMS), are closely monitoring private sector activities and making full use of the media to highlight any areas of controversy.

#### Enough Or Too Much

There are mixed views as to the likely future of private health provision in Scotland. There does appear to be a general acceptance that there is little scope for further expansion except possibly in the north where there are no planning applications in the pipeline. The central belt faces the possibility of a new hospital in Stirling, but the question which must be asked of the provision that already exists is – is there a demand to justify the supply or have the more recent developments been the victims of over-optimistic forecasting?

In Glasgow, because of their location at opposite ends of the city, the competition between Ross Hall and the Nuffield McAlpin Clinic is not as intense as it would have been had they been built nearer each other and competing for the same patients. As it was, while Ross Hall was being built, the Clinic was extending its facilities to provide another eighteen beds to add to the existing thirty-two. Although the two hospitals share the same outlook of the new breed of commercial hospitals there are quite vast differences between them, one focussing on a very expensive, high-technology approach, the other on a more informal low-key facility – the hotel-like interior of one contrasting with the more homely interior of the other.

Having accepted that it is possible for the two hospitals to co-exist there does appear to be general acceptance, however, that three private facilities in Glasgow amounts to possible over-supply but there are differing

views as to which will fall victim. The Nuffield McAlpin Clinic appears to enjoy the most secure position being the only major private facility in Scotland to enjoy a steady throughput of patients and maximum bed occupancy rates, and providing a service for one side of the city while Ross Hall and Bon Secours vie for patients at the other side.

Ross Hall is the least accessible of the Glasgow hospitals, being on the outskirts of the city, and is the only one not to be located "next door" to an NHS hospital, a location the unions posit as being of great advantage to a private hospital. It is possible that, had Ross Hall been built closer to Bon Secours they may have forced the latter to close in the face of competition, as the Order, similarly to that at St Raphaels, does not have the resources to compete realistically with firms which appear to have limitless amounts of cash to pour into their facilities. The fact that all the beds at Ross Hall are not yet functional has often been cited as "proof" that the anticipated demand has not materialised and its Director did indicate in 1984 that the pace of insurance has slowed with the corresponding result that occupancy rates had been below projections.<sup>(1)</sup> Perhaps the most that can be stated with any certainty is that the hospital is having to struggle to maintain its image, constantly aware of the scrutiny of the unions and suspicions of the general public, but whether it can master the struggle remains a question for the future. One thing which does appear to be certain is that it shall never enjoy the acceptance afforded its English counterparts. Staff in the Scottish private health sector show no hesitation in observing that their English equivalents have much better relations with the general public and with their colleagues in the NHS, face less pressure from health service unions, and rarely meet with the same kind of highly emotive, occasionally hostile reception which has been shown to arise in Scotland.

In Edinburgh, Murrayfield Hospital has not been open long enough to allow any real insights into its progress that could not be put down to initial hiccup but there have been some indications that this facility too is finding it difficult to find its feet and establish itself. Problems with the BTS were followed by a refusal from the Health Board to allow the hospital use of NHS laboratory facilities. For a hospital which prided itself on its cordial relations with the local community and the Health Board this was a blow and was followed by further adverse publicity when it was revealed in the media that NHS equipment was being used at the hospital without the Health Board's knowledge. Publicity has conspired to give the hospital a less than easy introduction into the local community but whether the hospital will eventually iron out the initial difficulties or whether it has been the victim of over-optimistic forecasting, having been planned at the height of the insurance boom, is impossible to determine.

Commercial private provision now has a steady footing in Scotland, particularly since establishment money has become involved through the promotion of "community" schemes and the government's Business Expansion Scheme, but it certainly seems unlikely to expand much further unless the government becomes radically more committed to taking active steps to promote its expansion, and there does remain the possibility that some contraction of existing facilities may take place.

### Privatisation of NHS Ancillary Services

The issue of the privatisation of NHS ancillary services is inextricably linked with the Conservative belief in the free market economy and cannot be detached from growing concern over the present government's commitment to the NHS and the growth of the private sector. The main intellectual stimulation for privatisation within the NHS came from Michael Forsyth (MP for Stirling and manager of a public relations firm one of whose clients is Pritchards, a firm active in tendering for private contracts in England) whose publication, "Reservicing Health" argued that NHS workers force the government to offer exorbitant wage increases thereby preventing money being spent on capital projects. He has also claimed that there is evidence that savings of between 25 – 50% can be made by contracting out cleaning and catering services but it is difficult to establish where such "evidence" has come from. It cannot be over-looked that privatisation of some services could *potentially* save money which could theoretically be fed back into the NHS (just as the money from council house sales could be used to boost a local authority housing budget instead of being used to offset cuts in the Housing Support Grant), but this has not been proven and must be weighted against the risks involved. Privatisation has now popularly come to be equated with efficiency, in-house services with waste and the relative merits and both sides of the issue have become obscured.

In September 1983 the Scottish Home and Health Department (SHHD) issued a Circular, (Gen)13, to Health Boards, asking them to, "test the cost-effectiveness of their domestic, catering and laundry services by seeking tenders for these services from outside contractors and comparing them with the cost of in-house services".<sup>(2)</sup> Response to the Circular was minimal and a second one, (Gen)14, was issued in June 1984 to "stimulate further progress".<sup>(3)</sup> This second Circular requested mainland Health Boards to put out to tender domestic and catering services for head offices and at least two hospitals by 31st December 1984 and to draw up a three year programme of reviewing and putting out to tender all their

ancillary services.

### The Scottish Response

Arguments against the ideology of NHS privatisation, which seem to consist of potential savings, reducing the power of the health unions, increasing efficiency and stimulating competition, have been well documented by the unions in their campaign against privatisation. The government has produced no evidence of efficiency savings except in uncharacteristic military hospitals and there are claims of more inefficient service where private contractors have been introduced. There are a number of ways in which private firms have been shown to be able to cut costs, such as undercutting on the initial tender and increasing costs once they have won the contract, taking on part-time employees at just below the number of hours when eligibility to various forms of statutory benefits takes effect, and by paring on security precautions but these measures have little to recommend them.

Health unions also fear that privatisation would introduce poorer working conditions as Health Boards have been instructed not to, "attach any preconditions to the tender documents, particularly on staffing matters, that are not related to work specifications".<sup>(4)</sup> This has led to fears that terms and conditions lower than the present Witley Council rates would be introduced and these fears were further fuelled when John McKay, the Scottish Health Minister, sent a letter to Health Boards in December 1984 telling chairmen that it would be wrong, and constitute unwarranted interference, for Health Boards to specify terms and conditions of service. He warned that attempts to do so would be against the interests of the Boards because it would restrict competition for contracts and increase tender prices.

Privatisation has its dangers for Health Boards as well as the unions in that it would reduce flexibility in the use of resources. Ancillary staff are an integral part of the health care team (a fact recognised by patients and not just a piece of union rhetoric) and are accountable to NHS management whose objective is patient care. If privatised, the objective is profitability and Health Boards would lose day-to-day control of services, including cost-control, which could leave them financially vulnerable in the eventuality of bankruptcy or some other such contingency.

Response to (Gen)13 was non-committal but in the interim before (Gen)14, the unions were building up a strong case highlighting the *practical* problems which privatisation poses rather than attempting to

combat the ideology, and mounting a vigorous campaign to educate the Health Boards on the issue. This tactic of working *with* the Health Boards in the face of a common threat is a departure from the more usual picture of Health Board/union conflict and illustrates how seriously the threat was viewed. The union strategy has been one of persuasion and involvement and a main aim was to help prove the efficiency of in-house services. Where Boards have agreed to seek outside tenders the unions hope to be involved in the specifications of the work required, with the emphasis remaining on co-operation, not conflict.

Five Boards (Argyll and Clyde; Fife; Greater Glasgow; Highland; Lothian) are refusing to comply with the Circulars. Six Boards (Ayrshire and Arran; Borders; Dumfries and Galloway; Grampian; Lanarkshire; Tayside) are intending to comply, and one Board (Forth Valley) is partially to comply by seeking quotes for domestic and catering services in three of its larger health centres, a move they were only asked "to consider". This picture must be qualified by the fact that the non-compliant Boards do intend to examine their present in-house services and look, with the co-operation of the unions, at ways of improving efficiency, and those who are intending to comply fully are unlikely to be able to do so within the set timetable. The response of the major Health Boards was strong and unanimous in opposition to privatisation and Greater Glasgow were particularly outspoken when they announced their decision not to comply. The Board voiced deep concern about the need to ensure the continuity of patient care and protection of standards which, along with incomplete re-organisation since the last reforms, were claimed to be the major influences behind the decision.

Scottish unions and Health Boards have proved their strong opposition to privatisation with a steady, concerted and well-thought-out campaign to prove its irrelevance to the Scottish health service. John McKay has written to the Health Boards who are refusing to comply, asking them to reconsider, but he has continued to rely on his powers of persuasion rather than resorting to threats or dictatorial orders. Union leaders feel that he is not really serious about the issue and is perhaps only half-heartedly attempting to keep in line with his English counterpart in the DHSS. It certainly appears unlikely that the Minister will pursue the issue with any great determination or legislate to enforce it. As things stand, if services deteriorate under private contractors then the unions could bring an injunction against the Health Board concerned on the grounds of deterioration of service and the threat to patient care. If, however, the Circulars were elevated to the status of Directives, then the Secretary of State would be the responsible party and this is not a role he is likely to

assume lightly in the knowledge that the health unions were continuing to monitor services closely.

The Health Boards have successfully delayed, if not halted, the government's plans and it has been suggested that the stage is now set for a confrontation between the Health Minister and the recalcitrant Health Boards. Such an analysis of the situation is perhaps questionable in view of the fact that one of the main objectives behind the Circulars has been attained. The Circulars did provide the impetus for Boards, even if not favouring privatisation, to scrutinise the efficiency of existing services and this compromise may have been enough to placate the Minister unless he faces further pressure from his colleagues down South.

The unions, far from becoming complacent, are still continuing to build up a dossier to illustrate the force of their case against privatisation. A TUC document highlighting the failure of private firms in the NHS in England, has been distributed to every Scottish Health Board. By outlining the nightmares Boards could find themselves in if they use private contractors without considering all the implications, the unions are continuing their campaign and as their case becomes increasingly watertight, the likelihood of the government's plans being realised becomes increasingly improbable.

#### National Health Service

Ironically, it is probably with the NHS that the fate of the private sector ultimately lies. Although there has been no proven correlation between cuts in NHS resources (the health budget has not actually been cut but the annual increase in resources is not enough to maintain services at their present level far less improve them) and a corresponding increase in the number of people choosing to seek private treatment, the possibility cannot be ruled out. The problem of industrial relations in the NHS, particularly in the late 1970s when the private sector began to flourish; the low levels of capital investment which allows buildings and standards to deteriorate; long surgical waiting list, 65,000 in 1981; 86,000 in 1982; 88,000 in 1983<sup>(5)</sup>; and overall financial stringencies can lead to consumer dissatisfaction and the seeking of alternative forms of care by those who can afford it. Until recently, opponents of private medicine in Scotland have tended to fight a rearguard action by attacking the private sector but failing to defend the NHS. It has now been realised that the time has come to meet the private sector on its own grounds to find out why people are choosing to go private and to bring the NHS up to these standards. To defend the NHS out and out and ignore its sometimes fundamental inadequacies, is to ignore part of the

raison d'être of the private sector. One of the starting points in defending the NHS has been to attempt to halt private sector abuses of the service and the unions have been increasingly active in this field in the past few years, giving the impression that abuse is becoming more widespread or more apparent as the private sector grows. Illegitimate use of NHS resources, abuse of NHS pay beds and abuse of NHS contracts by doctors doing private work, have all been highlighted in the media in recent years. There is very little sharing of private/NHS facilities in Scotland leaving the Scottish NHS more independent from the private sector than is the case in England where pooling of resources requires co-operative working relationships between the two sectors. In highlighting areas of abuse unions and Health Boards often appear to be in conflict with, and suspicious of, each other leaving it questionable whether they both have at heart the same interest of defending the NHS. A more positive response by Health Boards in taking action against abuse of NHS facilities and a less negative one by the unions who have the tendency to ascribe the dubious attributes of a minority to the majority, could perhaps bring some rationality back into the situation and reduce the petty conflicts which serve to mask the real problems. Until the problems confronting the NHS are overcome there will remain a real role for the private sector which would appear, in Scotland to be gaining many consumers by default rather than actually attracting them on the merits of what they have to offer.

### Conclusion

Private health care grew significantly in Scotland in the early 1980s but the trend has since slowed considerably and although private commercial hospital provision has established itself, it seems unlikely that there is much scope for further expansion. Similarly the growth of private health insurance appears to have stabilised after the dramatic expansion in 1982 and insurers agree that any future growth will be minimal unless the government alters its approach and provides the sector with more active encouragement than it has been prepared to do so thus far. The sector will almost certainly continue to grow, albeit possibly quite slowly, if the NHS continues to be seen as a deteriorating service, if waiting lists continue to grow and people become increasingly disillusioned with the capacity of the public sector to meet their needs. On the other hand, the sector could, in all probability, face a decrease in popularity if NHS services were seen to improve as the number of lapsed subscriptions indicate that many people cannot afford private treatment. It is possible that there is already an over-supply of provision, particularly in the west, because it expanded at a time when insurance subscriptions were increasing rapidly and expected to continue doing so.

The Scottish Health unions have played a large part in the battle against private health care and this role extended to their opposition to the privatisation of NHS ancillary services where their campaign has apparently been more successful than those in England. Small groups such as the Committee To Defend The NHS, Local Health Councils and a few outspoken doctors have been active with the unions in trying to protect the NHS but the core of these groups amounts to a very small number of people which tends to confirm the unions' view of the "nuisance value" of the sector rather than it being perceived as a real threat to the NHS. This "nuisance value" approach appears to be shared by more than the unions, however, given the dearth of published material on the private sector in Scottish health care. The small amount of work which exists on the issue of private health care generally tends to highlight the issue from an English perspective which is of little relevance to Scotland where the sector operates on a much smaller, and less readily acceptable, scale. It is virtually impossible to compare and analyse Scottish and English trends in private care because much of the necessary information does not exist for Scotland as a separate unit. Despite the lack of exact figures, however, it can still be concluded that Scotland, with its greater tradition of support for the voluntary sector and the NHS, is correspondingly more hostile to the private sector. It is not possible to determine how much weight should be attributed to the factors influencing the differences between the Scottish and English response to private health care, but it is probable that historical and cultural differences account for greater Scottish support for the NHS whereas it is almost certainly more militant trade union action which has helped to stave off the threat of the privatisation of NHS ancillary services.

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### References

1. Stuart Byron in *The Scotsman* 24th July 1984
2. Scottish Home and Health Department *Circular (Gen)13* Paragraph One
3. Scottish Home and Health Department *Circular (Gen)14* Paragraph One
4. *(Gen)13, op.cit* Appendix I, Paragraph 7

5. Scottish Home and Health Department *Scottish Health Statistics*  
December 1984